

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203



Division of Medicaid and Children's Health Operations / Region I

October 28, 2003

Lori H. Real, Director
Office of Health Planning and Medicaid
Department of Health and Human Services
129 Pleasant Street
Concord, New Hampshire 03301-3857

Dear Ms. Real:

This letter pertains to the 1915(b) (4) waiver request New Hampshire submitted on October 1, 2003 to selectively contract for a disease management program. All waiver requests under section 1915(b) of the Social Security Act (the Act) are subject to requirements that the State document the cost effectiveness of the project, its effect on recipient access to and quality of services, and its projected impact (42 CFR 431.55(b)(2)). After extensive analysis of the material submitted by the State, we believe that additional information is required before we can render a decision on the State's request. We therefore have enclosed a list of specific questions that must be addressed in order to respond to this request for additional information.

Under section 1915(f)(2) of the Act, a waiver request shall be deemed granted unless, within 90 days after the date of submission, the request is denied or the State is informed in writing of any additional information which is needed in order to make a final determination with respect to the request. Our enclosed request for additional information stops the 90 day review clock. The clock will restart for a second and final 90 day review period on the day the State's full response to our request is received. Please respond to our request within 90 days of the date of receipt of this letter.

Please note that on page 3, section II, item B, the effective date of the waiver application is a 2 year period, identified as January 1, 2004 through December 31, 2006. This is a 3 year time span. If you are requesting an effective begin date of January 1, 2004, the end date can be no later than December 31, 2005. Our staff will be available to assist the State in responding to this request and completing the waiver submission. Should you have any questions, please contact Harold Finn of my staff at (617) 565-1225.

Sincerely,

Bruce D. Greenstein
Associate Regional Administrator

Enclosure

**CMS Request for Additional Information on the
New Hampshire Section 1915(b)(4) Waiver --
Selective Contracting for Disease Management
October 22, 2003**

Waiver Application

- 1) Item II.J., p.4 – Will retroactive eligibility periods be included in the disease management program?
- 2) Item II.K, p. 5 – How will disease management services be provided to those individuals who do not have a telephone?
- 3) Item II.K, p. 5 – For non-ESRD enrollees, what criteria will be used to determine if an enrollee receives telephone or face-to-face services?
- 4) Item II.L, p. 5 – Please note that the independent assessment will also need to look at the impact of the waiver on access and quality. In your response to this question, please provide assurances that this will be done.
- 5) Item III.A, p. 7 – Is the program voluntary? If so, the requirement for choice of managed care plans need not be waived. The program may be considered voluntary if the State automatically assigns beneficiaries to the disease management organization, but permits them to opt out at any time.
- 6) Item III.A.2, p. 7 -- The proposal states that although beneficiaries will not have a choice of DMOs, McKesson has a policy that enrollees will be able to change telephonic disease management nurses if necessary. What criteria will be used to determine if it is necessary for an enrollee to change telephonic nurses?
- 7) Item III.C, p. 12 -- How often will the State require the "ongoing" contractor reports to ensure that nurse to enrollee ratios are such that enrollees obtain DM services?
- 8) Item III.C, p. 12 -- The application states that because of the "regional" nature of the Nurse Care Manager it will be more difficult to facilitate a switch from one nurse for in-person case management. If an enrollee using face-to-face services is unable to develop a productive relationship with his/her Nurse Care Manager, how is the situation remedied?
- 9) Item III.C, p. 12 -- Please describe the process used to assist enrollees in finding the appropriate Nurse Care Manager.
- 10) Item IV.E.1, p. 15 – How will the nurse consultant coordinate disease management efforts with primary care providers?

- 11) Item IV.E..2.(i)–(l), p.16 – Please confirm if this item was checked appropriately. If so, please provide more detail on the restriction on type of enrollees and how enrollees would be transferred to a different disease management organization (given there will only be is one organization). If this was checked in error, please note this in your response.
- 12) Section V. – There is a new methodology required to demonstrate cost-effectiveness under a section 1915(b) waiver. Attached are the instructions and relevant spreadsheets. Please replace the Section V in the original request with the attached. CMS can provide technical assistance in this new methodology, including setting up phone calls to walk relevant State staff through the process.
- 13) General – Is the State making any effort to coordinate this disease management program with the Collaboratives conducted by federally qualified health centers (FQHCs) in the state under the sponsorship of the Health Resources Service Administration’s Bureau of Primary care?

Source of Funding

- 14) Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking states to confirm to CMS that the Prepaid Ambulatory Health Plan (PAHP) in the Disease Management program retains 100 percent of the payments. Does the PAHP retain all of the Medicaid capitation payments? Does the entity participate in such activities as intergovernmental transfers or certified public expenditure payments, including the Federal and State share, or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization? If the PAHP is required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)
- 15) Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of the Medicaid capitation payment for the PAHP is funded. Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditures and State share amounts for the Medicaid capitation payment. If any of the state share is being provided through the use local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the State verifies that the expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).

16) Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to the PAHP.

17) Capitated Financial Question. Are there any actual or potential payments to the PAHP under this waiver/which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.) If so, how do these arrangements comply with the limits on payments in 42 CFR 438.6(c)(5) and 438.60 of the regulations?

If managed care contracts include mechanisms such as risk corridors, does the State recoup appropriate amount of any profits and return the Federal share of the excess to CMS on the quarterly expenditure reports?